Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.

PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Paediatric Products	
INITIATION Prerequisites (tick boxes where appropriate)  O Child is aged one to ten years	
and  The child is being fed via a tube or a tube is to be inserted for the purposes of feeding  Any condition causing malabsorption  Faltering growth in an infant/child  or  Increased nutritional requirements  or  The child is being transitioned from TPN or tube feeding to oral feeding  or  The child has eaten, or is expected to eat, little or nothing for 3 days	

I confirm that the above details are correct:	
Signed:	Date: